Chapter 8

Children with Disabilities

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Introduction

Children with disabilities are at higher risk than generic children (children who do not have disabilities) for becoming victims of criminal abuse. This chapter discusses the information and considerations for providing effective assessment and treatment when children with disabilities become crime victims. It is intended to acquaint therapists with the major types of disabilities, their impacts on children, additional effects of trauma, cultural stereotypes, and issues in treatment.

Disability and Maltreatment Risk

Children with disabilities are at increased risk for becoming victims of all types of abuse, when compared with children who do not have disabilities (Gil, 1970; Mahoney & Carrillo, 1998; Ryan, 1994). The abuse is more often chronic and severe, with re-victimization often caused by the same offender (Mahoney & Carrillo, 1998; Sobsey, 1994). Children with disabilities are maltreated 1.5 to 10 times more often than children without disabilities (Baladerian, 1991; Sandgrund, Gaines, & Green, 1974; Sobsey & Doe, 1991; Westat, Inc., 1991). Some children become disabled as a direct result of abuse. Approximately 60% of children with disabilities acquired their disabilities as the result of illness, accidental injury or abuse (Baladerian, 1991).

Incidence rates suggest that children with developmental disabilities may be 2 to 10 times more likely to be sexually abused than children without disabilities (Baladerian, 1991; Westat, 1991). Frequency of sexual abuse among children with developmental disabilities varies based on gender. For example, 39 to 83% of girls and 16 to 32% of boys with developmental disabilities are sexually abused by age 18, as compared 20 to 30% of girls and 10 to 15% of boys in the general population (Badgley, 1984; Hard, 1986; Baladerian, 1991; Finkelhor et al., 1989). Due to a number of factors that are discussed in this chapter, children with developmental disabilities are at significant risk and experience abuse quite frequently.

Families may not know that their children with disabilities are more likely to be victimized. They may believe (incorrectly) that a disability actually protects a child from victimization in some way. Because of this, the impact of trauma upon a family can be intensified when their mistaken sense of a child's safety is shattered. Families of children with disabilities receive a great deal of information about their child's specific disability and associated interventions, but this information rarely includes the increased risk of victimization. As a result, a family often does not provide a child with the conceptual and practical preparation for the possibility of victimization.

Such lack of training regarding abuse recognition and response can leave a child unprepared to recognize or respond to an assault. For some children, increased vulnerability results from the inability to resist an assault without specialized self-defense training. Even with such training, a child with communication deficits or mental retardation may be unable to resist an assault verbally or to report it afterwards. Assertion is not generally taught or tolerated in persons with disabilities; obedience, passivity, and compliance are more often reinforced. When an assault occurs, individuals with disabilities may not be emotionally prepared to resist. Perceived helplessness may, in fact, be "trained submissiveness." Unfortunately, training programs that teach abuse awareness and self- defense are provided infrequently to this most vulnerable population of children.

It is also helpful to examine the issue of vulnerability from the perspective of the offender. Based on stereotypes about persons with disabilities, some perpetrators intentionally select children with disabilities because they assume that such a victim will be helpless or passive. This belief can be valid in terms of

completing a particular assault, but it may not be true with respect to the child's ability to report the assault accurately. Perpetrators take advantage of the knowledge that family members may hold the incorrect belief that no helpers (relatives, professionals, or volunteers) would harm a child with a disability. This misconception contributes to the parents' denial of obvious and subtle signs of abuse and also makes it easier for the abuser to continue the abusive activities.

Perpetrators understand the opportunity for increased access to children with disabilities due to their need for therapies, evaluations, and daily personal care services such as dressing, bathing and toilet assistance. Perpetrators may seek jobs as home care assistants or in institutional settings. Once established in a helping role, perpetrators can exploit their trusted position. Staff may be slow to recognize or report abuse out of a belief that people with disabilities are not sexually attractive. These factors can bolster a perpetrator's sense of safety in selecting children with disabilities as targets for abuse. They apply equally to perpetrators who are family members, and to those who purposely acquire positions that provide them with professional access to children.

Although children with disabilities are victimized at rates far exceeding those for other children, they are less likely to have their cases substantiated and much less likely to be referred for psychotherapy. Those in a position to recommend treatment may not believe that a child with a disability can benefit from psychotherapy, may be unaware of funding sources, or may lack knowledge about referral resources. It is important for practitioners to be aware that in 99% of abuse cases of children with disabilities, the perpetrator is known to (and trusted by) the child and the family, in contrast to approximately 87% for other children (Department of Health and Human Services, National Child Abuse and Neglect Data Systems, 1997). When abuse occurs, the impact of having the perpetrator as a part of one's daily or regular life experience is significantly different from the abuse having been committed by someone unknown to the child. Issues of safety, trust and abandonment are more significantly affected.

Disability Types

The following sections describe several major areas of disability, with examples. It is important to remember that a child can have more than one type of disability.

Developmental Disabilities

Certain impairments that occur in childhood have a significant impact on a child's developmental process and progress. Developmental disability is a legal term that defines eligibility for services funded through federal or state agencies. Since developmental disabilities have been identified, codified and funded separate from other types of disability, these definitions and service systems receive special mention here. No other disability type has been identified by legislation for special consideration.

The following is the Federal definition of developmental disabilities contained in Section 504 of Public Law 95-602 Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978:

"The term 'developmental disability' means a severe, chronic disability of a person which is:

- attributable to a mental or physical impairment or combination of mental and physical impairments;
- manifested before the person attains the age twenty-two;
- likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities:
    - self-care
    - receptive and expressive language
    - learning

- mobility
- self-direction
- capacity for independent living, and economic self-sufficiency;

- and which reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

To be eligible for services funded by the California Department of Developmental Services, individuals must have a developmental disability as defined in Section 4512 of the California Welfare and Institutions Code. Section 4512 defines developmental disability as follows:

> A disability, which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

Cognitive Impairments

Cognitive impairments are conditions that affect one's ability to learn, think, read or write.

Mental Retardation

Mental retardation is defined in the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) as significantly below-average general intellectual functioning. It is measured by IQ tests yielding scores that categorize the individual's severity of mental retardation as Mild, Moderate, Severe, Profound and Unspecified. Children with IQs measured at 69 or below are identified as having mental retardation. Scores between 70–79 are considered indicative of Borderline intellectual functioning. There is impairment in adaptive skills and the ability to learn and understand academic subjects, but this does not imply that social relationships or emotional capacity are impaired. Mental retardation is estimated to affect 3–5% of the child population.

Learning Disabilities

These are disabilities that interfere with academic learning and communication, including dyslexia and difficulties with visual and auditory perception and processing. Learning disabilities have been estimated to occur in 1% to 30% of the general population, depending on the definitions used in a particular study. The most widely agreed upon range is 2% to 3% (Department of Education, 1986).

Traumatic Brain Injuries

Traumatic brain injuries (TBI) occur due to accidents, violence and more rarely, medical conditions. Children with TBI usually had no prior impairment. Many brain injuries cause difficulties with thinking, intelligence and memory, and with sensory and motor functioning.

Communication Impairments

Communication impairments include psychological and physical conditions that interfere with fluent verbal reception, expression, and speech production. Individuals with cerebral palsy, neurological disabilities and traumatic injuries often have difficulty with speech production.

Language and Speech Impairments

Developmental receptive and expressive language disorders are diagnosed when scores on language tests are substantially below scores on nonverbal tests of intellectual capacity. This demonstrates that the language impairment (not mental retardation) interferes with academic achievement or activities of daily living requiring the expression of verbal (or sign) language. There may be markedly limited vocabulary, understanding or use of only simple sentences, or speaking only in the present tense. In less severe cases, there may be difficulty in understanding specific types of words, such as spatial terms, or an inability to comprehend complex statements.

Physical Impediments to Speech Production

Many conditions cause difficulty in speech production, including brain damage (cerebral palsy, stroke) and physical construction. One example of the latter is cleft palate. Cleft palate is a congenital physical malformation which makes speech production difficult for the speaker. A cleft lip is a separation of the upper lip; cleft palate is an opening in the roof of the mouth. These comprise the fourth most common birth defect in the United States. Through surgery some cases can be repaired or improved surgically. Children can receive speech therapy to improve speech clarity for either type of problem.

Autism

Autism is a mental condition that affects social interaction, communication (expressive and receptive), empathy for the feelings of other people, comfort with physical contact and attention, and play activity. Epidemiological studies have found autism to occur at rates as low as 1 in 10,000 births or as high as 20 in 10,000 births (Centers for Disease Control, 2000), with four times more boys than girls having the condition. The etiology is unknown, and its course in a child cannot be predicted definitively. Levels range from mild to severe. A mild form of autism may be difficult to distinguish from mild mental retardation or Asperger's Disorder, because both have some but not all characteristics of autism. Most children with autism require special education. Behavior therapy is the current most frequently used treatment.

The child with autism may demonstrate what are termed stereotypic behaviors. The following patterns of behavior are observed in children with autism, although individual behaviors are not necessarily pathognomic of autism: sudden verbal utterances or increased volume; rocking back and forth; unusual hand movements (such as hand flapping); self-hitting; biting; rapid pacing; repetitive movements, sounds or behaviors; unusual use of toys; self-stimulation of eyes, head, ears, or skin; preference for or avoidance of certain words; bodily stiffness; and distress over changes in the environment or daily routine. Children with autism have the normal range of intellectual ability, although some may demonstrate exceptional ability in specific areas.

Sensory Impairments

Impairments in hearing and sight can create powerful effects on the autonomy and interactional abilities of an affected individual.

Hearing Impairment and Deafness

Many children are born with hearing impairments; others acquire a hearing impairment when physically abused (head trauma), through illness (especially high fevers and simple ear infections), or by accident. The Department of Education (1995) estimates that 1.3% of students have hearing impairments. Most people with a hearing impairment have some degree of sound perception, although this varies greatly. Children with hearing impairments often have delays in their academic progress due to communication problems, not learning or cognitive deficits.

Vision Impairment and Blindness

Children with blindness or vision impairment often have some vision, varying from none to the ability to read printed materials using magnification. Only about 10% of blind people use Braille. The Department of

Education (1995) estimates that approximately 13 out of a thousand children have significant vision impairment. Blindness, like hearing impairment, can be congenital, perinatal or postnatal. Blindness in the postnatal phase can result from accident, illness or other injury. An injury can result from trauma to the eye, through blows or exposure to toxins, or from burns. Conditions which lead to blindness such as retinitis pigmentosa generally have their onset in late childhood or adulthood (ages 10–30). However, other conditions may result in vision impairment due to neural damage (for example, toxoplasmosis or sexually transmitted diseases such as chlamydia). The disability of blind children is obvious, so perpetrators easily identify them as potential victims.

Sensitivity to Touch

A number of physical conditions can make children hypersensitive or hyposensitive to touch. Examples include Prader-Willi Syndrome (Brandt & Rosen, 1998) and lesions of the parietal-cerebral cortex (Tomberg & Desmedt, 1999). The child may have a physical reaction of pain or extreme discomfort, or the child may have a negative psychological response to touch. Children with autism are particularly sensitive. Some children have a diminished sense of pain. This is a dangerous condition, as they may not know when they are physically injured.

Motor Impairments

Motor impairments impair mobility. They affect the ability to transfer (move from one place to another such as from a wheelchair to a bed), walk, transport, and perform personal care activities (self feeding, bathing and dressing).

Cerebral Palsy

Cerebral palsy is a central nervous system condition that arises from an injury. The injury can occur at birth, usually when a delayed or difficult delivery results in the child's being deprived of oxygen (anoxia). Cerebral palsy can also be acquired from later anoxia or other head trauma. This is not a spinal cord injury, but rather an injury to the brain in the area where motor functions lie. There are several types of cerebral palsy, as well as levels of severity. Many people with cerebral palsy are able to walk without using any appliances, while others require a wheelchair. Since Cerebral palsy affects the muscles, including the face, there can be difficulties in speech production. The March of Dimes Birth Defects Foundation (1999) estimates that the proportion of the child population with cerebral palsy ranges from 2–3 per 1000.

People with cerebral palsy vary in their ability to speak. Many use verbal speech, and it takes little time to learn to understand them. Some use communication boards that others can read, where words are indicated or spelled out letter by letter by the child. Others use assistive computerized communications technology that allows a recorded voice to convert the words and letters indicated on a keyboard into speech.

Muscular Dystrophy

Muscular Dystrophy is a progressive medical disorder that impairs motor function. It differs from cerebral palsy, which is a static condition.

Orthopaedic Disabilities

Some children may not have all their extremities due to genetic or congenital factors, or as a result of an accident or illness that required amputation. These children most likely have learned an abundance of adaptive techniques to accomplish regular daily living tasks.

Chronic Physical Conditions

Children may have medical conditions that require daily or weekly medication and therapies. Some conditions may be episodic in its presence or severity. Others are progressive and degenerative in nature, causing a steady decline in functional ability. These include conditions such as hemophilia (a genetic disorder that affects the blood's ability to clot) and sickle cell disease (an inherited disorder which affects the

hemoglobin in red blood cells). Sickle cell disease makes a child more susceptible to infections and cause problems such as delayed growth, frequent urination, and subclinical neurological deficits.

Psychiatric Disorders

Many psychiatric conditions have a profound effect on a child and complicate a child's reaction to trauma. The psychiatric conditions most commonly encountered in traumatized children and adolescents are: Attention Deficit Hyperactivity Disorder (ADHD), mood and anxiety disorders, schizophrenia, bipolar disorder, obsessive compulsive disorders, dissociative disorders, oppositional-defiant disorder, and conduct disorders.

Myths and Stereotypes

When working with any culturally distinct group, it is important to examine one's own attitudes and beliefs in order to correct misconceptions. Most people have acquired some myths, stereotypes and negative values about people with disabilities. Your client may have experienced the effects of these negative beliefs:

Myth of Spread. People with one disability usually have more. For example, "If a person has cerebral palsy, he probably also has mental retardation." Another example can be seen in the behavior of food servers who ask a companion of a blind person: "What do they want to order" as if they were also deaf. While it is true that some persons have more than one disability, most do not.

Myth of Deviancy and Evil. "People who are disabled are bad and should be avoided if possible." In fact, people with disabilities do not commit crimes or other antisocial acts with any greater frequency than the general population.

Myth of Contagion. "If a person has a disability, another person can catch it and become disabled also." Many people fear touching or being near persons with disabilities. This can lead to avoidance of physical and visual closeness to disabled people, resulting in increased ignorance due to isolation and segregation.

Myth of Innocence. "Persons with mental retardation are 'God's little angels' and therefore asexual and good." This can lead to an unwillingness to acknowledge normal sexual behavior as well as sexual abuse or exploitation. Such false beliefs, when held by police officers or protective service workers, can contribute to the inadequate investigation of valid reports.

Myth of Wildness. "Persons with mental retardation are much like animals and require control. Without control, they are like marauding sex fiends and should not be allowed into the community." Such ideas allow for overreactions to affectionate behavior. Persons with developmental disabilities may be prohibited from normal caring behaviors that the generic population enjoys free of censure or programmatic intervention.

Myth of Eccentricity. Individuals of high social status or perceived value to society are granted "idiosyncrasy credit" to behave in deviant ways. For example, a university mathematics professor who carries a Mickey Mouse lunchbox is accepted, while the same behavior in an adult who works in a sheltered workshop may be viewed as infantile. Because people with disabilities are perceived as having less value to society, their idiosyncrasies are less likely to be tolerated.

Myth of Stupidity. "Disabled people are dumb. Because of their stupidity, they don't feel things like normal people do." People with retardation do learn and feel. Beliefs that children with severe mental retardation do not understand or have "normal feelings," contribute to a lack of treatment opportunity for abused children. Another behavior this belief engenders is talking about the individual in their presence in a detrimental or negative fashion as if they were not there or cannot understand. Children with mental retardation report sadness about hearing hurtful remarks.

When we encounter someone who has a disability or disfigurement, feelings of fear and revulsion can arise. These feelings can be overcome by focusing on the person rather than their appearance. However, sometimes a comfort level cannot be achieved. This is not something to be ashamed of. No therapist can adapt to every human condition. Therapists should be aware of their own reactions and limitations. However, if a therapist is unable to overcome negative responses to a child with a particular disability, it is appropriate to refer the child to another therapist. It is not a professional or personal deficit to have difficulty with particular client characteristics. Although professional growth is an important aspect of one's work, a therapist is not obligated to be self-critical for being unable or unwilling to work with a particular individual. A child can be successfully referred to those professionals who have more interest, expertise or specialization in working with children who have a particular type of disability.

Reactions to Individuals with Disabilities

When meeting persons with disabilities, many individuals experience socially conditioned feelings of embarrassment and shame. Because of this, persons with disabilities may be avoided, either fully (through segregation) or by lowering one's eyes in their presence (to avoid eye contact), and by not speaking to or greeting them in casual situations. This can include an experience of confusion about whether to acknowledge the disability, as if its visibility made it a proper subject of inquiry. An effective way to handle meeting or greeting someone with a disability is to begin by simply saying, "Hello."

Our culture sometimes promotes fear of disabilities and pity for people who have them. Individuals with disabilities grow up in the same culture and may also internalize such negative stereotypes. People can respond with fear to a child with a disability because it reminds them that their own physical integrity is not permanent. Sometimes when an individual with a disability does something ordinary, their accomplishment gets exaggerated (for example, as "courageous"). Such exaggeration belies the pity hidden underneath. We should not feel guilty for having these feelings, but use them to promote an understanding of others. When treating a child with a disability, the therapist should move beyond pity to actually getting to know that child. The child needs the therapist to focus on the victimization they have experienced and on their abilities, personality, and coping resources.

Understanding the Child with a Disability

Developmental Issues

Each child responds to trauma in distinct ways. Children who experience trauma may regress to earlier levels of development or temporarily lose skills that they had already mastered. The lifestyle and experiences of a child with a disability are generally different from those of other children. Because of this, their response to trauma must be considered within their particular context. They may have a more difficult time making sense of a traumatic experience. Children with disabilities are often sheltered from normal life experience. They may not have received information in a way that they could understand and may have even been ignored within their family. Often children with disabilities are excluded from family discussions about daily experiences, plans for adulthood (college, career), social life (boyfriends and girlfriends) and school. When the child with a disability becomes a crime victim, this pattern of limited communication tends to continue. Children with disabilities are frequently excluded from discussions and explanations about the victimization and subsequent events. The therapist can help alleviate feelings of confusion and anxiety by supporting and modeling the child's inclusion in all relevant discussions with family members.

Sometimes the "mental age" concept (from intelligence testing) is misapplied to all aspects of an individual's life and functioning. This confuses treatment planning, misunderstands the child, and can also be ineffective and insulting. Physical and sexual development may outpace emotional readiness or intellectual ability, but a child's chronological age should always be considered. A 12-year-old child may be entering puberty and beginning to experience romantic and sexual feelings. If this is disregarded or slighted, it can be experienced by the child as disrespectful and as showing that the therapist does not understand him or her. The

additional challenges that occur with disability are primarily related to the child's cognitive and communication skills, as well as differences in the child's daily routines.

Disability and Sense of Self

Children with disabilities are usually aware that they have a disability, that they are different, and that there are limitations placed on their activities. Their reaction to the disability is influenced primarily by how the parents and other family members treat the child and disability-related issues, the child's own inborn spirit and attitude, and the cause of the disability. The child's perspective about their disability, the family's view of the disability and the child's feelings about the cause of the disability should be explored during therapy. A child with a disability may have had more restrictions placed on interactions with the environment by parents and teachers. A twelve-year-old girl with moderate mental retardation may have never been unsupervised. She may have believed that the world is a safe place. It is difficult to comprehend trauma in a world that has always been safe.

A disability is not a child's only identity. Many children with disabilities are in fact quite competent and view themselves as competent. A child also has a sense of self that includes gender, place in the family, race, religion, ethnicity, culture, socioeconomic status, academic achievements and grade level in school (as an "important" 6th grader, or a Senior rather than a Junior).

Guiding Principles for Treating Children with Disabilities

Normalization

Normalization means that children (and adults) who have a disability should have the opportunity to live a lifestyle as close to normal as possible. They should participate in family, school, religious, social and neighborhood activities just like their peers. They should be treated according to their chronological age, with respect for their individual differences. For example, a 15-year-old who has mental retardation should not be given a book written for and about children six years of age, but rather a book about teenagers written at a level consistent with their reading and comprehension.

Least Restrictive Environment

This principle states that the individual with a disability should receive treatment services that allow the greatest degree of autonomy. For example, if a child can benefit from available outpatient treatment, this is preferable to inpatient hospitalization. Least Restrictive Environment (LRE) is the requirement in Federal law that children with disabilities receive their education, to the maximum extent appropriate, with nondisabled peers and that special education pupils are not removed from regular classes unless, even with supplemental aids and services, education in regular classes cannot be achieved satisfactorily (see United States Code Section 1412(a)(5)(A)).

Sensitive Use of Language

One should avoid language that demeans, distances and dehumanizes. The correct approach emphasizes dignity and individuality. For example, one should avoid saying "the retarded one" and instead use the given name (for example, "Suzanne") or, if it is important to identify the child's disability, name the person first and then the disability information. For example, "Maria, the child who has mental retardation." This implies that the child has a condition, not that the child is the condition. Sensitivity about language usage is of critical importance to assure a successful therapeutic alliance.

Treatment Issues

Responses to Victimization

There can be wide variation in symptom expression in children with disabilities when compared with the posttraumatic stress disorder (PTSD) criteria found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV). For example, some children with a developmental disability may

appear asymptomatic following a trauma, or symptom expression can be delayed. Other children develop new behaviors such as refusing to eat solid foods, elective mutism, refusing to change into nightwear to go to bed, running away, or re-enacting abuse with others. A child with a disability — just like a child without a disability — may show an increase in negative behaviors that were present prior to the assault, such as stubbornness, oppositional behavior, short temper, and bouts of anger.

Therapists must be aware that many children with disabilities may have never learned to identify and name feelings. They may be familiar with the names of primary feelings (for example, mad, sad, or glad), but they may not have learned to identify more subtle feelings (for example, shame, embarrassment, guilt or confusion). In the early stages of therapy, it is especially important to help children learn to identify and name their emotions. This activity also provides an opportunity for the therapist to assess the child's overall comprehension and expression of feeling words and phrases.

Many children with disabilities are accustomed to having their bodies touched by others for purposes of daily personal care, medical examination and physical therapy. Such frequent physical contact can interfere with the development of boundaries and a sense of body integrity. It is a common misperception that children with mental retardation do not understand sexuality and social relationships well enough to make credible reports of sexual maltreatment. Most children with disabilities can be expected to experience sexual maltreatment as inappropriate and wrong. Professionals who work with children with severe intellectual impairments have noted that such children do in fact demonstrate feelings of invasion and shame accompanying sexual maltreatment. Therefore, their reports should not be discounted as misinterpretations of normal physical care or social interaction, or in the mistaken belief that such children do not understand the significance of the assault or, worse, that they do not have feelings.

Children with disabilities are often taught to avoid trouble at all costs (either trouble for themselves or for someone else). If a child discloses maltreatment, it is likely that the perpetrator will get into trouble, causing the child to feel guilty and frightened. With information and support, most children with disabilities can state that they want the perpetrator to be held accountable for their behavior. Without such support, it is less likely that the child victim can overcome feelings of guilt that inhibit disclosure of victimization.

Multidisciplinary Model for Treatment

One of the major issues for therapists working with child victims with disabilities is the greater number of service providers involved and the time-consuming nature of case coordination. When providing treatment, the therapist must be aware of other professionals and service providers who interact with the child, and coordinate treatment with them. The child benefits most when service providers work together in a consistent manner. To make this happen, communication between all parties is essential.

Treatment Issues Involving Parents

The way that parents originally learned about their child's disability may have been traumatic for them, and can impact how they treat this child as compared to their other children. Parents can have difficulty accepting the disability of their child. Some may take a religious perspective that God has sent this child to them, either as a punishment or as a special gift or responsibility. The parents may be pressured by well-intended family, friends or professionals to institutionalize their child "for the child's own good." The question of what placement is best for a particular child and their family is complex and beyond the scope of this chapter. The therapist should try to understand how the parents view their child's disability and the choices they have made regarding the child's care.

For parents of children with disabilities, child-focused time, activity and commitment is substantially greater than for a generic child. Parents learn to give the child's needs priority over their own physical and emotional needs. Parents have already been faced with their own emotional responses to their child having a disability. The stages of grief described by Elisabeth Kübler-Ross (1997) can be applied to the process of adjusting to a child's disability. These include: seeking someone to blame (self, spouse, doctor, and so on);

denial (hoping that this is a temporary state or that the doctor is wrong, or "doctor shopping" to find a more hopeful prognosis); depression and a feeling of being overwhelmed; and finally acceptance of the disability and commitment to doing everything possible to foster the child's abilities. Therapists need to be aware of these phases and to assess the parents' adjustment to their child's disability.

As in all child trauma cases, inclusion of the parent or caregiver is an integral part of the therapy. The child's reaction to the trauma may be strange to the parent, and the parent will need assistance to respond to the child's symptoms (nightmares, sleep walking, anger, stubbornness, self-injury, and so on.) in a positive manner. The parents may feel that the traumatic abuse the child has experienced is "too much" for them, and that they have already endured as much as they are able. Additionally, the parents may have their own distress symptoms in response to the crime against their child and may need their own individual and family therapy. When a child experiences trauma, the most important factor in the healing process is a parent or caregiver who believes, supports, and protects the child. Understanding the parents' psychological adjustment to the disability of their child and to the current traumatic event influences treatment interventions. Parents may need referral to support groups, disability resources, advocacy regarding education and medical care, information about assistive devices, and case management services.

Treatment Issues with Children

Having a disability does not necessarily mean that the child has a poor self-image or problems with confidence. However, the clinician should be aware that all areas of the child's life could be affected. When children are raised in well-functioning families, are treated with respect, and receive the supportive equipment and services they need, there is no reason to expect that the child will have psychological or social problems. A good initial history explores all of these areas and its findings should be reflected in the diagnostic picture and resulting treatment plan.

Therapy with children with disabilities relies on play, tactile and role-playing strategies. The usual child treatment materials can be used, depending upon the individual child's level and type of impairment. If parents have overprotected their child, some expected age-appropriate skills might not have been taught or mastered (for example, if a teenager initiates a hug with the therapist at the first meeting). Teaching age-appropriate behavior to both the child and parent is required and can be placed in the context of safety planning. Children who have been sexually molested can present a particular problem when it comes to the expression of physical affection in family and everyday life. It is crucial to recognize that sexually molested children may have an entirely different feeling about and expectation of expressions of physical affection from what they had before they were molested. Helping these children to recover and to feel safer must involve teaching them that they can set and assert boundaries for the expression of physical affection. Where to set those boundaries varies from case to case and must take into account individual, familial, and cultural circumstances, but it is an essential part of therapy that boundaries be set and practiced.

Treatment plans should follow the same standard as for all children, with descriptions and modifications as required for the child. The course of treatment may be longer or shorter than for a generic child, or may be more episodic. The session itself may be shorter, if the attention span or the child's tolerance is shorter than for other children. Substantial family involvement may be required along with collateral sessions with siblings, teachers, residential placement staff, extended family or others.

Treatment Considerations for Selected Types of Disability

A disability can affect all aspects of a child's life, including vulnerability and response to trauma. The design and implementation of a treatment plan must consider the type of disability. It is important to understand the child's belief system regarding their disability. A child may already feel different from and perhaps "less than" other children. This pre-existing negative self-image can be exacerbated by trauma. Therapists should provide corrective information that a disability is "a difference not a deficit," and that any child could become an abuse victim.

The clinician is encouraged to consult literature on the type(s) of disability the child has. However, if information about the impact of trauma on children with a specific disability is not readily available (for example, on the Internet), the clinician is encouraged to consult with a professional who is familiar with the disability in question. The following sections address treatment issues relating to some specific disabilities.

Learning Disabilities

There are many types of learning disabilities. The clinician may want to review some basic material on issues of language processing (expressive and receptive, auditory and visual). While some learning disabilities only involve written expression and may not affect the therapy process, others can seriously interfere with a child's verbal communication. It may help to consult with the child's teachers to learn the most effective communication strategies.

Traumatic Brain Injuries

If a neurological medical file is available, the clinician should review the extent and implication of the injuries (see the "Legal Issues" chapter for information on access to confidential records). If a TBI or less severe head injury has caused significant hearing or speech impairment, the child must learn new ways to communicate such as writing, sign language, or communication boards. If the injury has resulted in blindness, paralysis or other major impairment, mental health treatment must address these challenges. Finally, if the child has acquired a permanent disability as a result of the trauma, there may be an additional emotional overlay of anger, grief and mourning. When an injury has resulted from parental abuse, the family dynamics and legal issues are more complex. For more information on intrafamilial abuse, see the chapter on Treatment Issues in Intrafamilial Abuse.

Physical Impediments to Speech Production

Therapists often find it difficult to understand children with speech impediments. Time and practice conversing with the child usually lead to better understanding. The task force recommends consulting with those close to the child (parents, teachers, childcare providers) to learn what techniques to use to improve comprehension. In addition, the therapist can learn from the child's communication strategies and encourage the child to correct the therapist's misunderstandings.

Autism

Children with autism vary in intellectual ability. Many children with autism can respond to psychotherapeutic treatment, although their level of cognitive functioning will affect the techniques chosen. Their responsiveness to therapy is similar to their responsiveness in other areas. At times, slower progress can be expected, so patience is required. Using the child's primary mode of communication is important, as is understanding the conditions typical of autism, such as echolalia (repeating what has just been said).

Some children with autism can benefit from play therapy, educational therapy (learning to name feelings, matching face drawings with named feelings, and making faces that express the feelings), and role playing. Repetitive behavior is characteristic of autism, and repetition of therapy steps may be expected. It can be difficult to engage children with autism in conversation. The child may avoid eye contact. They may speak of themselves in the third person. Their thinking and expressions may be concrete. Social graces and manners may not have been mastered, and this can interfere with general social interactions. The therapist should expect unusual social interactions with the child involving personal space, unusual mannerisms, excessive and erratic energy and movement, loudness of voice, and interactional asynchrony (disruption of conversational rhythm).

Some autistic children engage in self-abusive behavior (self-hitting, biting, head-banging). If these occur during therapy, it is most helpful for the therapist to remain calm and not communicate alarm. Self-abusive behaviors may indicate stress, which signals the therapist to stop the current activity or discussion, and divert attention to something different. If this does not assist the child to control the self-abusive behavior, the session should be ended. A serious and persistent pattern of self-abusive behavior requires expert consultation and should be considered a primary treatment concern.

Hearing Impairment or Deafness

It is important to know at what age a hearing impairment first occurred, to place the therapy in the correct context of the child's sensory life experience. In addition, the therapist should ask both the child and parents what communication methods have been used by the child since the onset of the impairment. For some hearing-impaired children, hearing aids are sufficient for comprehension. Other children rely upon a combination of hearing aids and lip reading. Controversy exists between those who believe that lip reading alone is the best approach for teaching deaf children to communicate and those who promote total communication methods, which include sign language and all other forms of understanding a conversational partner. American Sign Language (ASL) has given many deaf children complete fluency in communicating with others who use ASL, resulting in a strong sense of community among them. However, most deaf children who use ASL have parents who do not understand or learn it (Wolkomir, 1992). Such parents do not speak their child's language. In addition, parents who do not acquire a Telephone Device for the Deaf or speech impaired (TDD) leave their child unable to make social or emergency telephone calls. Such barriers to communication must be considered as part of treatment.

The task force does not expect every therapist to learn ASL, although learning a second language is always a useful skill. It is optimal if the therapist working with a child trauma victim who is deaf or hearing-impaired is also fluent in that child's language (spoken English, signed English, finger spelling, American Sign Language, British Sign Language, and so on). If not, the therapist must hire a Certified Interpreter for therapy sessions. The therapist is responsible for paying for the interpreter.[1] For children who are deaf, the therapist needs an interpreter present for all sessions. As with any language need, if there is an equally qualified therapist available who is fluent in the child's language, that therapist is preferred and a referral should be made.

A child with hearing or vision impairments may have delays in academic progress. An assessment of their general knowledge should be conducted to ensure an effective treatment plan. If the therapist does not have expertise assessing sensory-impaired children, a referral should be made. Consultation with the child's family and teachers can assist the therapist in developing effective treatment strategies.

Blindness and Vision Impairment

It is important to know at what age the child became blind and the cause of the blindness. If the child has experienced vision, the concepts of color, shapes and space, among others, are easier to address. The emphasis should be placed on the child's experience in the world, social experiences, body integrity, personal safety issues, and risk reduction strategies. Play therapy, role playing and psycho-educational activities are excellent therapies.

Hypersensitivity to Touch

A child with touch sensitivity may react negatively to an unexpected touch. The therapist should always ask permission before touching and should apologize immediately when inadvertent physical contact occurs. The therapist should ask caregivers whether sensitivity to touch is a concern for their child.

Orthopaedic Disability

When a child's orthopaedic disability was present before the traumatic event that is the focus of therapy, the child and parents have probably adjusted to the disability already. It is useful to inquire as to how that process of resolution took place, what assistance was available, what barriers to adjustment occurred, and what residual feelings remain. In contrast, if the disability is the result of the trauma in question, the child's adjustment to this condition will be central to the treatment plan.

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[1] The Victims of Crime Program will reimburse the cost of an interpreter for hearing-impaired children with approved VOC claims.

The therapist may need to make adjustments to the office furniture to allow the child to move about autonomously during therapy sessions. Depending on the disability, the therapist should ask the child how they generally accomplish activities such as reading, playing, drawing, and so on. The therapist should learn how to deal with phantom pain (perceived pain in a missing limb). The experience of pain is real, so the therapist should never tell the child that there is no pain or otherwise deny the child's experience.

Some therapists may feel uncomfortable when treating a child with an orthopaedic disability. It is normal to feel apprehensive initially when faced with missing limbs or a bodily deformity. These feeling are usually due to a lack of experience with such conditions and typically alleviate as the therapist gets to know the child. If the therapist continues to have difficulty, consultation and supervision should be obtained.

Psychiatric Disorders

Children with psychiatric conditions often require psychiatric evaluation and medication to assist with impairments in mood, thought or behavior. Consultation with a pediatric psychiatrist is recommended prior to or in the early stages of initiating treatment, in order to assist with diagnosis and treatment planning. This also helps the clinician understand the child's medication schedule and the best times to schedule appointments for optimal benefit. It is often difficult to conduct therapy unless a child has been properly medicated and the therapy will likely be ineffective. Even with appropriate medication, stress can trigger difficult or assaultive behavior in some children. It is important that the clinician obtain training in managing such escalations of mood and behavior. Often, simply discontinuing the activity or conversation that stimulated the stress can begin de-escalation, as can stopping the session or moving to an unrelated activity. Consultation with the child's teacher and other service providers also provides information as to the best ways in which to help children manage their moods and behaviors.

Special Assistive Devices

Adjustment to new ways of communicating with clients requires adaptability and acceptance by the therapist. Therapists should learn about assistive devices or special techniques for mobility or communication. These include prosthetics, wheelchairs, walkers, crutches or canes. Communication techniques include American Sign Language (ASL) and lip-reading for the deaf, hand-signing for deaf-blind individuals, and Braille. Interpreters may be used if the child is deaf, deaf-blind, or has a speech production impairment. Computers or communication boards with words, letters of symbols can be used for expressive communication so that the child can initiate or respond to conversation.

Teaching Crime Prevention Skills

Treatment should include crime prevention skills to reduce the likelihood or impact of further maltreatment. This requires the development of a practical, individualized plan with the child and family's active participation. A risk reduction plan that involves the child and parents can reduce fear, increase confidence, and empower the child to be effective in either avoiding an assault or ameliorating its psychological impact. Such a plan does not require complex self-defense skills, such as biting, kicking, hitting, and so on. It can be as simple as making an agreement that the child will tell someone as soon as maltreatment is attempted or completed. The plan should be well-rehearsed with both the child and family. The child should always be told that they are blameless and that the full responsibility lies with the perpetrator. This cannot be overemphasized.

Laws Regarding Individuals with Disabilities

Individuals with Disabilities Education Act (IDEA)

The Individuals with Disabilities Education Act states that all children with disabilities have a right to a free and appropriate education. This law mandates that each child must have an Individualized Education Plan (IEP) in which all educational activities are integrated. The therapist should request a copy of these plans from the school district and participate either directly or through consultation in order to coordinate future treatment plans. An IEP identifies a child's need for therapies or services that contribute to and enhance the child's learning. The school district has the legal responsibility to develop a proposed IEP based upon

assessments they have conducted. Their proposal is discussed in a formal meeting with the parent or authorized guardian, who must agree to the plan and any proposed revisions. The parent can bring others to the meeting, including attorneys who specialize in Special Education law. In addition, each family has a Family Service Plan (FSP). The FSP process is similar to the IEP, but also includes representatives from collateral agencies that provide services to the child.

Lanterman Act

In 1968 the State of California developed a network of "Regional Centers." These non-profit agencies contract with the State Department of Developmental Services to provide services to all state residents who have developmental disabilities. Although a Regional Center does not provide the services directly, it approves and pays for services that are identified as required for a child's well-being, including diagnosis that determines eligibility. The "one-stop" Regional Centers offer case management to eligible members by creating an Individual Program Plan (IPP). These plans are created together with the family, service providers and others as needed. They include a review of most areas of the child's life: educational, residential, medical, psychological and developmental. An IPP contains information about a child's traumatic experiences, along with corresponding plans for intervention. The Regional Center case manager is a part of the multidisciplinary team and is responsible for the coordination of treatment as allowed by the family. The therapist should develop a working relationship with the case manager and request a copy of the IPP. The therapist can participate in the IPP meetings and provide input for services the child may need and that the Regional Center can obtain. The Regional Centers also provide a "Client's Rights Advocate" who can be called upon to assist when there are difficulties finding needed services.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act mandates that all services offered to the public be accessible to persons who have a disability. Any agencies and individuals that serve victims of crime have a responsibility to provide full access to enter and make appropriate use of their physical offices and services. For more information, refer to the U.S. Department of Justice (www.usdoj.gov/crt/ada/adahom1.htm) or American Psychological Association (www.apa.org/pi/cdip/adainformation.html).

Conclusion

Clinicians who treat children should be aware of the special risks and vulnerabilities to victimization faced by children with disabilities. Traumatized children with disabilities need a supportive response from family, therapists and society. Children with disabilities can benefit from psychotherapy to recover from trauma when clinicians recognize their potential and acquire the expertise needed for effective treatment. The task force encourages clinicians to become more responsive to the treatment needs of children with disabilities and to be in compliance with the Americans with Disabilities Act.

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